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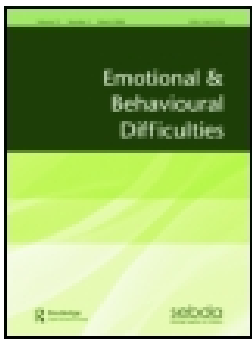
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'It's a bit taboo': a qualitative study of Norwegian adolescents' perceptions of mental healthcare services

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ABSTRACT

The aim of this study is to investigate adolescents' perspectives on mental healthcare services. Based on theoretical perspectives concerning barriers for help-seeking, individual interviews were carried out in order to obtain the adolescents' perspectives on knowledge of services for mental health problems, potential barriers for help-seeking, and services to which they have access. The sample consisted of vocational students from an upper secondary school in the southwest of Norway ($n = 8$). None of the informants was currently in treatment for mental health problems. Interview data were transcribed and analysed with the assistance of NVivo Software. Qualitative content analysis indicated that the adolescents have limited knowledge of available resources, and, that stigma-related factors may prevent the adolescents from seeking help for mental health problems. Future directions for delivering mental health services for adolescents are given.

KEYWORDS

Adolescents; mental health; stigma; barriers; help-seeking

Introduction

The number of Norwegian adolescents with mental health problems is concerningly high. At any given time, 15–20% of Norwegian children and adolescents between the ages 3 and 18 years experience reduced functioning due to mental health problems (The Norwegian Institute of Public Health: Rapport 2014:4 2014:4). Adolescents report that they struggle with mental health issues on an everyday basis, mainly in terms of high levels of distress, and adolescents struggling to fit in at school, in the family and in other social arenas experience this to a higher degree (NOVA 2015). Symptoms of anxiety and depression are increasingly reported in non-clinical older adolescents. Feelings of anxiety and depression are higher among girls than boys (NOVA 2015) and half of the dropout rate in upper secondary school is due to such problems (Sikveland 2013). Studies also indicate that the mental health problems of 20–40% of adolescents with symptoms of anxiety and depression continue into adulthood (Mykletun, Knudsen, and Mathiesen 2009). Anxiety disorders are common in this age group and depressive symptoms increase with age and often occur simultaneously with anxiety (Aune 2011). In sum, the prevalence of mental health disorders in Norway is similar to that of other European countries and in the USA (Mykletun, Knudsen, and Mathiesen 2009, 8).

In Norway, local mental healthcare services are available to the adolescents, such as school nurses/counsellors, Educational and Psychological Counselling Service (PPT), and services at adolescent health centres. Adolescents may also receive services from the specialist healthcare services. However, few receive appropriate help, a circumstance found throughout the world (e.g. Heflinger and Hinshaw 2010; Merikangas et al. 2010; Hunt and Eisenberg 2010; Chandra and Minkovitz 2007; Ford, Goodman, and Meltzer 2003). Several individual aspects predict help-seeking not only regarding mental health problems, such as availability and costs (Burgoyne and Hafner-Ranabauer 1998) but also regarding attitudes such as fear of stigmatisation (Vogel, Wade, and Hackler 2007). Stigma may be defined as a mark or sign of disgrace bringing negative attitudes to its bearer (Thornicroft et al. 2007). It may also be viewed as an overarching term for difficulties related to stigma, such as knowledge, attitudes and behaviour (Thornicroft et al. 2007). Stigma associated with having a mental disorder is in fact a huge barrier to effective care regarding mental health problems (Barney et al. 2006). Also, among younger non-clinical adolescents, stigma is a crucial barrier regarding the use of mental health services (Chandra and Minkovitz 2007). Studies indicate that adolescents who endorse the mental illness stigma are less likely to obtain needed care (Heflinger and Hinshaw 2010). Perceptions about a treatment's success mediate the link between stigma and treatment as perceptions of stigma are less important when adolescents believe that the treatment is likely to succeed (Penn et al. 2012). Research on middle and older adolescents further suggests that perceived stigma among adolescents is associated with gender (being male) (Andersson et al. 2010; Rapee et al. 2006) and higher externalising levels (Rapee et al. 2006). There are, however, research gaps in this area, specifically regarding context and development of stigmatising views among adolescents (Chandra and Minkovitz 2007).

Regarding delivery of mental health programmes for adolescents, universal programmes have been found to reduce stigma, however, at the expense of smaller individual effects for the adolescents and greater impersonality when it comes to the relation between participants and professional caregivers (Offord et al. 1998). In contrast, stigma is more evident in indicated or targeted programmes, which also include more personal contact between participants and professional caregivers and higher client satisfaction (Offord et al. 1998). Less fear of stigma is crucial to seeking help for mental health problems (Skre et al. 2013), and peer teasing and embarrassment predict mental health negatively (Rapee et al. 2006). As experienced stigma may predict a negative response to interventions (Moos 2005), it is important to further investigate the role of anticipated and experienced stigma in mental health services, as well as adolescents' perceptions and attitudes regarding mental health.

Theoretical foundation concerning barriers for help-seeking

As stigma is a major barrier to care-seeking and/or treatment participation, it is a significant health concern also in mental healthcare (Corrigan 2004). Theoretically, stigma can be divided into three domains: cognitive (e.g. stereotyped knowledge/beliefs), affective (e.g. negative affects) and behavioural (e.g. avoidance/isolation/discrimination) (Byrne 2000). Stigma in mental healthcare describes a social-cognitive process that motivates people to avoid the label 'mental illness' and is a major reason why many people who may benefit from mental health treatments choose either not to fully adhere to treatment or not to obtain treatment at all (Corrigan 2004). One behavioural aspect of stigma, discrimination, can be defined as 'rejection of and negative behaviour towards people with mental health problems' (Lasalvia et al. 2013, 56). Discriminatory behaviour occurs either as negative action for those who are stigmatised (such as avoidance) or as positive action for those who are not (Corrigan 2004). Effects of discrimination (e.g. lack of access to care, social marginalisation) can be consequences of either actual experienced discrimination or anticipated discrimination (Lasalvia et al. 2013). In fact, anticipated stigma can have similar effects as behavioural stigma. For instance, research shows that depressed individuals who are concerned about stigma may adapt their social behaviour to avoid exposure to discrimination, hence developing a negative circle between anticipated stigma and the effect of

stigma at a behavioural or functional level (Lasalvia et al. 2013). Such adaptation is similar to what has been called 'self-stigma' (when stigmatised individuals internalise a public stigma) and 'public stigma' (when prejudice about a stigmatised group is endorsed by the public), a distinction used in more general work with all health conditions (Corrigan 2004). Public stigma, also called 'perceived stigma' (Moses 2010), such as stereotype, prejudice and discrimination, can deprive those who are labelled mentally ill in obtaining jobs, finding suitable housing and receiving proper insurance benefits (Corrigan 2004). Furthermore, when it is not the mental health system but rather the police that responds to mental health crises it can criminalise mental illness and increase the prevalence of people with a mental health problem in jail, and, people labelled mentally ill receive fewer medical services than those not so labelled (Corrigan 2004). Thus, being labelled mentally ill by the public brings harm to those so labelled and may lead to the latter either avoiding this harm by concealing their problems or avoiding it all together by denying them (Corrigan 2004). The latter is a main reason why stigma influences care-seeking and treatment adherence (Corrigan 2004). Furthermore, public stigma influences self-stigma as those diagnosed with a psychiatric disorder tend to internalise stigmatising ideas from their surroundings, such as being of less value due to their diagnosis, leading to self-prejudice and self-discrimination, which again influence quality of life (Corrigan 2004). Thus, self-stigma may lead to avoidance and decreased participation in treatment (Corrigan 2004).

As for adolescents' experience of stigma, studies have indicated that peer stigmatisation is an important stigma domain (Moses 2010; Chandra and Minkovitz 2007). Important stigma components regarding help-seeking in young people include personal stigma, perceived stigma and social distance (Wright, Jorm, and Mackinnon 2011). Studies have also shown that diagnosed youth who experience perceived stigma in one domain will additionally experience perceived stigma in other domains, that is, from family members, peers and school staff (Moses 2010). Perceived stigma can be very challenging for adolescents due to their age-related concerns (e.g. identity consolidation, peer acceptance, social image) and hence reduce adolescents' coping regarding stigmatisation (Moses 2010). Adolescents experience a development period including considerable cognitive, emotional and physical changes, a period that may bring forth behavioural changes leading to psychological distress (Chandra and Minkovitz 2007). Concealing problems due to experienced stigma can generate more problems, such as loss of social support and anticipatory anxiety (Crocker and Garcia 2006; Quinn 2006). Adolescents' anticipation of discrimination from peers, family members or school staff is crucial with respect to adolescents' actually addressing their mental health problems (Chandra and Minkovitz 2007). Adolescents diagnosed with a mental disorder who experience stigma from school staff do so either positively (e.g. support) or negatively (e.g. underestimation of abilities) (Moses 2010). When aiming to reduce stigmatisation of youth with mental health problems, it is important to make those close to the youth aware of potential stigmatisation and its influence on the adolescents (Moses 2010).

The current study

The main aim of this study is to investigate a sample of non-clinical Norwegian upper secondary school students' perspectives on mental healthcare to reveal factors that may cause the adolescents to avoid help-seeking for mental health problems if such help should become necessary. We wanted to explore how adolescents believe that mental health services can best be delivered, thoughts on how healthcare professionals can reach adolescents, and potential experience of stigma. We seek to reach these aims by tentatively answering the following research questions: (1) Which mental health services are the adolescents familiar with? (2) What are the obstacles that make adolescents avoid seeking help for mental health problems? (3) In the adolescents' opinion, what should be the content of and who should deliver such services?

Method

Procedure

An interview guide was developed to carry out semi-structured interviews. The guide was based on the theory on stigma, such as exploring perspectives on what may be a barrier for the adolescents regarding the actual addressing of mental health problems (Chandra and Minkovitz 2007), what may hinder help-seeking for mental health problems if necessary (Corrigan 2004), and if there are any actual experienced or anticipated discrimination (Lasalvia et al. 2013). Although the interview questions were open ended, they were quite structured and had clearly defined purpose to the responses they were asking of the interviewee. Questions were mostly framed so that the adolescents responded in a general and not a personal manner, addressing adolescents' knowledge and wishes regarding mental health services and factors influencing help-seeking for mental health problems. The questions from the interview guide are presented in Table 1.

Sample

The participants ($n = 8$) were all pupils in late adolescence from the same vocational class at an upper secondary school in the southwest of Norway. A school counsellor who worked with preventive mental healthcare in the community and was part of the researchers' network was contacted for advice on potential schools to be contacted for the current study. She suggested recruiting from the school she works in, as the study fit in with the current curriculum in one of the classes (i.e. research and research methods) and to give the pupils a good learning experience. Hence, the school and class were chosen based on practicalities. The school represents an average regarding reported depressive symptoms among adolescents in comparison with other adolescents of similar age, both within municipalities of the same size and regarding national numbers (NOVA 2015).

One of the researchers gave a presentation to the class about research and the current project. All of the pupils in the class were invited to participate. The informants volunteered for the interviews (i.e. purposive self-selection). The sample consisted of six girls and two boys; all were 18 years old but one, who was 17 years old. None of the informants was currently utilising any mental health services nor had any previous mental health difficulties. One girl had previous

Table 1. Interview questions.

General questions regarding mental health services for adolescents	What knowledge do you have regarding mental health services for adolescents (e.g. adolescents who feel depressed or experience difficulties, or just want to cope better)? Do you or anyone else in your age group experience any obstacles when it comes to seeking mental health services? If so, what? Do you believe that there are any general attitudes (norms) in your age group regarding seeking mental health services? If so, what are they?
Specifically about thoughts regarding mental health services	If you were struggling some, were a bit blue, angry or just needed to learn how to cope with life better, what services would you like to be available for you? What do you think that such services should cover (e.g. to learn more about distress or mental health, about different diagnoses/diseases or anything else)? If you were to choose, where should such services be provided (e.g. at school, at adolescent health centres, a doctor's office, adolescent leisure centre or anywhere else)? What personnel should offer such services (e.g. doctors, psychologists, school nurse, school counsellor, teachers or other adults)? What is a good way to announce/inform about mental health services for adolescents?
Background information	Age, gender, course of education
Debrief	Give thanks, ask about any uncertainties, anything to elaborate on or to withdraw, how the interview experience was

contact with the school nurse and one with the Educational and Psychological Counselling Service (PPT) and childcare services. One girl had immigrant background.

Data collection

The individual interviews were carried out in November and December 2014 in a private location on school grounds (i.e. conference room) during school hours. Each interview took a maximum of 20 min to complete. All interviews were recorded and transcribed. In addition, field notes were taken.

Data analysis

Qualitative content analysis can be defined as 'a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns' (Hsieh and Shannon 2005, 1278). This approach was chosen to explore the data guided by the seven classic steps of the analytical process in qualitative content analysis, that is, to formulate research questions, select the sample, define categories to be applied, outline the coding process, implement the coding process, determine trustworthiness and analyse the results of the coding process (Kaid 1989). A deductive category application (Mayring 2000) was performed by employing existing theory and research on stigma to help focus the research questions of the study, to explore variables of interest and to aid in the initial coding of the data.

Directed content analysis followed (Hsieh and Shannon 2005). A coding scheme was developed, and data were analysed with the assistance of Nvivo Software (QSR International). First, the transcribed interviews were read by the Norwegian authors and predefined codes and inductive themes were discussed. Key concepts and variables were identified as initial coding categories by main themes from the interview guide. Operational definitions for each category were determined. To focus the data, they were immediately coded with the predetermined codes. Potential overlap between themes was accounted for by categorising the theme within the code in which it fitted the best, and, in some cases themes were coded under the same category. For example, as all data describing 'barriers' included 'attitudes', the text that included both 'barriers' and 'attitudes' was coded under the node 'barriers'. Hence, no text only referred to a node called 'attitudes'. As 'content', 'arena', 'personnel' and 'information' all referred to 'wanted services', they were coded as sub-nodes to the node 'wanted services'. See Table 2 for an overview of the coding steps and the content of the codes.

Qualitative studies have no rigid guidelines regarding number of informants needed to perform data analysis. However, having enough data to compare the interviews' content is one objective. Hence, if there were not enough data gathered to compare the interviews' content after the eight interviews, further interviews would have been needed. Furthermore, inviting the adolescents to participate could result in a very small or very large number of informants, and saturation was set as a goal regarding number of interviewees needed. Hence, if saturation was not met after conducting these eight interviews, further interviews would have been needed. However, based on the gathered data and analysis of same, it was believed that performing additional interviews would not reveal new information that had not previously been revealed. Furthermore, the interviews provided enough information for comparisons.

The interviews were carried out by a female researcher aged 38, experienced in qualitative methodology and individual and group interviews. The analysis was performed in collaboration between researchers with different educational background of which two also have clinical experience, one has a dual role as clinician and researcher. Hence, different perspectives were represented. The researchers responsible for the data analysis coded each transcript, followed by a discussion on the potential results. The same authors all agreed in the analysis of the data and the dimensions that generated from it.

Table 2. The coding process of the study.

Step 1: key concepts	Known services	Barriers for help-seeking	Attitudes hindering help-seeking	Wanted services	Content of services	Arena for services	Responsible personnel	Announce and inform about services
Step 2: Operational definitions			Knowledge base <ul style="list-style-type: none">Existing knowledge			Stigma <ul style="list-style-type: none">BarriersAttitudes		Future directions <ul style="list-style-type: none">Wanted services
Step 3: Coding			'Known services'			'Barriers' <ul style="list-style-type: none">Attitudes		'Wanted services' <ul style="list-style-type: none">ContentArenaPersonnelInformation

Ethics

The study was formally approved in the Regional Committee for Medical and Health Research Ethics in Norway and at Stavanger University Hospital, Norway. Informed consent was gathered prior to the interviews.

Results

The adolescents presented several factors regarding their perspectives on mental health services. The data are presented below in the following three main dimensions: 'known services', 'barriers' and 'wanted services'. See Table 3 for examples of quotations under each dimension and sub-dimension. All names are anonymised.

Known services

Regarding 'known services' (i.e. services the adolescents are familiar with and/or know exist), most of the adolescents mentioned school services such as school counsellors and school nurses. 'I know there are services at school, such as with the school nurse, and that they can get you a psychologist if necessary' (Edith, 17 years). However, although the students referred to school counsellors as 'known services', the data revealed that the students did not necessarily know that the school counsellor provides services other than strictly educational advice. 'But the school counsellor, isn't he only counsellor for education, and ... because that's what I believe. (...) Like, you go to him to talk about what happens after high school and about studies' (Sarah, 18 years). The adolescents also mentioned psychologists and local healthcare services. 'I know we have an adolescent health

Table 3. Examples of quotations from each dimension and sub-dimension.

Dimension	Sub-dimension	Quotation
Known services		'There's the school nurse and the adolescent health center. There's a school counsellor at school. I guess there are other services in the municipality as well, but mostly school nurse at the school and at the health center. I know there is a psychiatric nurse at school on Wednesdays'
Barriers		'(...) if you cannot be anonymous, that is a big problem. Because a lot of people become very suspicious if they cannot be anonymous. So I think it is very important because they do not want everyone to know that they have a problem. (...) Everybody thinks like that because no one wants anyone else to know that they have mental issues (...) No one wants that label (...)'
Wanted services		'Earlier (...) we always had a conversation with the school nurse, I miss that here (...). It is much easier when you are put in a room with a person and talk about it there. (...) 'cause then no one thinks 'oh, there's someone who is going there to talk with someone', but when everyone does it nobody get suspicious. (...) it's like during adolescence it is often during the first years at high school that most have difficulties, while it builds up to it during upper secondary class. That's what I've seen in my environment, I know a lot of people and we see what's going on'
	Content	'It could be that you first learned something about it, kind of, because we don't know much about it, really. And then receive help afterwards (...) 'cause then you know a bit more about what's wrong with you, sort of'
	Arena	'I think it should be held at school because it's a very safe area. Because I don't think I would have participated if it was somewhere else. Because then I wouldn't have recognised the place and wouldn't know who showed up. But I would have at school, sort of'
	Personnel	'It should be a person that came by every now and then, who worked with it, for instance a psychologist'
	Information	'Again, it's through social media, that's where people are. Facebook, I don't know anyone who's not on Facebook. (...) Newspapers, to go through them is very smart. (...) Social media is the place, at school you forget about it and notes we receive are put in our backpacks and forgotten as well'

centre' (Sarah, 18 years). Few of the adolescents in the current sample mentioned diagnosis-specific services. Those mentioned were for depression, eating disorders and TIPS (Tidlig oppdagelse og behandling av psykose) (i.e. early intervention for psychosis, a help-line for symptoms of psychosis). 'I've heard about several services (...). I know about (services for) eating disorders (...). There is also (services for) depression' (Leah, 18 years). 'And TIPS. That's a phone you could call' (June, 18 years). Some mentioned arenas for healthcare services outside the school, such as the Internet, ads in the newspapers, leaflets, emergency rooms (ERs), Educational and Psychological Counselling Service (PPT) and childcare services. '(...) I also know that if you search the web, like, that if you need someone to talk to, numbers pop up, and (...) I'm not quite sure what it is. Webpages, yes. (...) maybe questions, right, where people have difficulties, there are answers, what you have to do and such, yes' (Sarah, 18 years). '(...) in the newspaper I see ads for like "if you have problems you can call this number' (Edith, 17 years). 'There are brochures out there (in the waiting room at the school counsellors' office); '(...) and that one at the emergency room (...) but that's more for those who have been abused or something' (Leah, 18 years). 'The school nurse. I've had contact with PPT because of the child care services, those I know about' (Ruth, 18 years).

Barriers

Regarding 'barriers' for help-seeking for mental health problems, many of the adolescents mentioned terms related to concern about their 'anonymity' and 'that other people know about their problems'. Other words used to describe such barriers were 'fear', 'embarrassment' and 'uncomfortable'. 'You know, talking to somebody is just embarrassing, right? It is just embarrassing' (Sarah, 18 years). Mental health problems were described as 'taboo' and associated with a lot of 'prejudice'. 'When you are at the adolescent health centre ... It might be that the first step of just getting there is a bit difficult, because (...) you might have to wait before you can enter the office and then all of a sudden there are people there that know you ... And they might ask you why you are there ... (...) What if they tell anybody else and start rumours (...) I don't think that I would dare to take that first step of just entering the building' (Sarah, 18 years) and 'everyone wants to manage by themselves (...) they do not want to show that they are not ok' (June, 18 years). Mental health problems were called 'lame', 'difficult' and 'scary', and the adolescents said that seeking help 'decreases ones strength'. 'It is one of those things you just don't, at least in our group of friends, talk about. (...) you are supposed to talk about nice stuff with your friends. You kind of have one person to talk about such things with, and others you don't'. (Rita, 18 years) and 'you do not feel less worth, but you feel a bit "down there" compared to others. So it is embarrassing to contact anyone, kind of. And it sort of reduces your own strength'. (Leah, 18 years). The adolescents said that those experiencing mental health problems no longer have the 'standard', 'rank' or 'pride' that adolescents without such problems have. 'Pride is a big one. I feel that people take themselves too seriously because I feel that there is a very high standard you are supposed to maintain and if you do something like that (seek mental health services) you put yourself below the standard of being perfect' (Tobias, 18 years) and 'mainly if you are afraid that people will think that something is wrong with you, that you can lose friends if anyone should find out (...) A lot of people hide it because many see it as uncomfortable to talk about' (Jakob, 18 years). Finally, seeking help for mental health issues involves breaking the 'code', is of 'no use' or destroys the 'family's pride', or the adolescents do not have the 'time' to address mental health matters. 'It's a bit taboo (...) there is some sort of code on how to be. (...) it has to do with where you are ranked, school environment for instance. Those who are in the middle and lower have it somewhat easier than those who are higher up (...). They (those in the middle and lower) have few and very close friends compared to those who have more and less close friends and who are not open about everything to everyone' (Ruth, 18 years).

Wanted services

With respect to 'wanted services', informants said that they wanted to 'talk with someone', mainly the school nurse or in a group setting. Psychologists or close family/friends were also mentioned. Some wanted to work on their own problems in solitude, by using books, the Internet or music. 'I would have talked to myself and brought myself back in, that's usually what works (...). Music often helps and listening to a song you can recognise yourself in, and just to sit alone and do what you like to do, and enter a blog on the web, for instance' (Jakob, 18 years). Some mentioned that they wanted to attend services during or after school, preferably mandatory services. 'To make it the same for all students (...) I believe it would be very useful that everyone, in the beginning of the school year, had an individual session with the school nurse (...) it doesn't help much to talk with your teacher about what you want for the school year. (...) it also has to do with what you want socially (...). If it was mandatory, kind of. It would have been like "ok, now I'm going to the school nurse". It's not like it's abnormal in a way. Everyone is going, right?' (Sarah, 18 years).

The data from the interviews on this dimension were further categorised into the four sub-dimensions of 'content', 'arena', 'personnel' and 'information'.

Content

As for 'content', most informants wanted to talk about different coping skills related to both general and more specific issues regarding mental health. 'Different techniques to cope with different problems. And also questions to make me reflect a bit more and, yes, get new perspectives on things' (Edith, 17 years); 'In some courses, psychology for instance, you learn some. It should be more general and more info at school so that it would be easier for people to seek (help) so that they know more. Included in the curricula so that we learn a bit more about mental health in the courses' (Ruth, 18 years) and 'first and foremost, in Norway at least, what's the problem with us, adolescents? We live in a society where we really don't have to be that stressed out. We complain a lot about things we really don't have to complain about. We get pretty depressed, more than we really need to be, we have a wrong mind-set compared to where we really are. It is pretty important that we can change our perspective regarding what's happening with us. (...) if a teacher asked "what is your perspective on this and that" because it's very important to make people think, not just on themselves (...) then you have other things to think about, and it helps a lot' (Tobias, 18 years). Specific subjects mentioned were coping with stress, depression and eating disorders. 'I think stress (...) should be in the curriculum in a way' (Sarah, 18 years); 'there are different lectures that we've attended or listened in on. On such days you learn quite a lot. But I think that if you seek help, then you have a problem you kind of want help to solve. Then it's only that subject (...). It's not necessary to sit and talk about all kinds of stuff, right? When it's not about me and the reason you're actually there' (Rita, 18 years) and 'I would say eating disorders and depression (...). First and foremost you learn what it is, but you could also learn some about what you can do if you or someone you know has it' (Leah, 18 years).

Arena

The school and recreation centres for adolescents were the two main arenas the informants wanted to establish such services. 'I really think that it would be best to have it at school and that, kind of, most people participate so that, again, no one feels that "oh, I have to register for that because there's other people also who have difficulties". But then again it could be kind of ok to talk with other people who have ... are in the same situation. So it's kind of difficult, really' (June, 18 years). 'If it would have been at an adolescent recreational centre I would have felt that it would be an ok part of my life. (...). If held at school I think that I would like to have my own leisure time to myself when in school (...) so for instance during psychology classes' (Tobias, 18 years). General information on mental health issues was suggested during class/lectures. Some informants wanted

individual conversations with an adult and some wanted to learn more about mental health issues in group settings. The Internet and adolescent health centres were also briefly mentioned. 'At school, easiest, or nearby, adolescent recreation centre or the adolescent health centre. At school during class' (Ruth, 18 years); '(...) it's ok with the school because you are at school. But I don't think many people go to the adolescent health centre, really. I think it's more through school' (Rita, 18 years) and '(...) should have somewhere central (...), possibly at an adolescent recreation centre (...) but there's also the school' (Leah, 18 years).

Personnel

As for 'personnel', the informants expressed that they wanted someone with the proper training to carry out such services. 'Someone educated within mental health. At least I would feel a bit more assured that they knew what they were doing' (Edith, 17 years). Examples given were psychologists, school nurses, others from the mental healthcare sector, medical doctors and others not related to the school. 'Someone specialised on the topic, a psychologist (...). It may be expensive, but it is actually something the school needs, because there's a lot of people that have it lousy (...)' (Jakob, 18 years) and 'not just a teacher who has read a bit about it and "yes, come to me if you have questions", kind of. But someone who really knows about it, yes. It's only better if it is someone outside the school, because then you don't feel that they know you and can judge you because of that' (June, 18 years). Few mentioned teachers as an alternative. 'A philosophy teacher could be very useful. (...) or someone with some psychology, I believe at least one of the two' (Tobias, 18 years). One informant thought it would be a problem if teachers were responsible, while another thought it would be ok. 'Doctors. (...) I don't know, I kind of feel that it's the psychologist's job (...) but the school nurses, they do almost the same. (...) But not teachers. (...) I think it's better that a person you might not see as often and has the class knows that much' (Sarah, 18 years) and 'I think it's very ok to listen to lectures because I think that helps a lot of people (...). That people think that "wow, they were far out there" and you might get some inspiration to "ok, maybe I should do it as well, perhaps it's normal" (...). You don't want people to recognise themselves in your situation, but it does make it easier' (Rita, 18 years). Some were also indifferent regarding who provided the services. 'Everyone can give information about it, and just mention it during class (...). It's a bit tricky because I'm kind of "outgoing", so it's easy for me to say "no, to me it's the same who does it"' (Leah, 18 years).

Information

In the final sub-dimension, 'information', social media was described as the main platform for informing about such services. 'Yes, everyone is on Facebook, almost everyone anyways (...). Make such information that pops up, kind of. That it's there' (Sarah, 18 years); 'you could have had a Facebook page because then everyone will know about it very easily. Because brochures go straight into the trash. Or you don't see them. Or if you could get it on the Internet because everyone is on the Internet. On social media or something. Everyone is on Facebook, so that would have worked, I guess. (...) You could have had posters as well, but I think it would be best to tell classes and then put it on the Internet' (Edith, 17 years); 'most people have Facebook, so there's a big source ...' (June, 18 years); 'Internet, that's where people are, so through social media (...)' (Jakob, 18 years) and 'it must be Facebook' (Ruth, 18 years). Next was the school. 'I believe that a lot of (...) people coming to the school and give lectures (...) and we don't have a regular school day. (...) it makes more out of it when a person comes and tells a story, that you kind of get insight into the person's history as well' (Rita, 18 years) and 'adolescents today have been really good at ignoring posters, and when teachers enter classes they have become really good at ignoring and I find that pretty sad. (...) so the best way must be to enter the classroom and tell about it' (Tobias, 18 years). Posters and web pages were also briefly mentioned. 'Social media are the easiest (...) Facebook is pretty easy. (...) It's useless to be on Instagram or Twitter (...). But there could also be posters at the schools (...), I think that would help' (Leah, 18 years).

Discussion

In this study, a community sample of Norwegian adolescents' perspectives on mental health services was investigated. The focus was on their knowledge of such services, potential barriers for help-seeking and the services to which the adolescents wish they had access. In short, the findings suggest that these adolescents have some knowledge of available resources; however, this knowledge is limited. Furthermore, stigma-related factors may prevent the adolescents from seeking help for mental health problems. The findings also suggest future directions for delivering mental health services to this specific target group.

An interesting finding was the adolescents' perspectives regarding barriers to help-seeking for mental health problems. What can be interpreted to be anticipated stigma seems to explain the barriers mentioned to a high extent. The mentioning of 'code' and 'rank' may suggest that the adolescents experience pressure regarding who they are in terms of clothing, make-up, potential friends and, not the least, regarding mental health problems, the latter being undesirable and something 'taboo' and/or 'embarrassing'. The finding that the adolescents are reluctant to talk about mental health problems with their friends is supported elsewhere (Chandra and Minkovitz 2007). Talking with friends about difficulties in general, including mental health problems, was described as being easier for those with fewer but closer friends in comparison with those with many friends which were not as close. Furthermore, as seeking help for mental health problems may decrease one's 'ranking' and hence have considerable social consequences for adolescents, such ranking may hinder them in seeking necessary help. Such ranking may lead to adolescents only socialising with peers within their perceived 'rank order'. Socialising with peers situated similarly when it comes to 'rank' can be positive in that this may preserve the adolescents' self-esteem through provision of emotional support and favourable social validation (Crocker and Major 1989; Major 2006). However, it can also have negative consequences such as limiting adolescents' social circle as well as their social skills (Crocker and Garcia 2006; Miller 2006; Moses 2010). Social consequences are crucial for teens' utilisation of mental health services (Chandra and Minkovitz 2007). Hence, peers' negative perspectives on mental health problems and mental health services seem to be a great barrier to help-seeking for the adolescents which also can strengthen anticipated stigma. The notion that mental health problems are something negative is supported by other research showing that younger adolescents describe such problems as something to avoid and tease about; this is related to a person's weakness and hence negative anticipation regarding peer responses to such problems (Chandra and Minkovitz 2007). Thus, behavioural stigma may hinder adolescents in seeking help for mental health problems and avoiding being labelled as someone with a mental disorder seems very important to the adolescents. The negative effect of stigma on help-seeking for mental health problems is supported by other research (Clement et al. 2015). The somewhat limited knowledge regarding available resources for mental health problems may also be a barrier to help-seeking. More knowledge regarding what resources are available and how the resources aid adolescents with their problems may lower the threshold for help-seeking.

The finding that the adolescents have limited knowledge regarding available resources for mental health problems may also, to a certain extent, explain some of the anticipated and/or experienced stigmatising behaviours. Lack of knowledge regarding mental health problems and available services may lead to ignorance and stigma. Younger adolescents with limited and/or inaccurate information regarding mental health disorders have more stigmatised attitudes towards people with mental health problems (Chandra and Minkovitz 2007). Hence, there is a need to focus on how to reduce stigma related to mental health problems. One approach may be to increase the adolescents' mental health literacy. Mental health literacy has to do with the ability to recognise mental disorders, a person's knowledge and beliefs about risk factors and causes of such disorders and a person's knowledge about available self-help interventions and professional help (Jorm 2000, 2012). Research suggests that teens with less knowledge regarding mental health have a more negative attitude towards such problems than informed students and that such disapproving views

of individuals with mental illness can change after gaining knowledge about mental health (Chandra and Minkovitz 2007). Furthermore, adolescents experience moderate levels of stigma regarding mental health problems and have low mental health literacy (Chandra and Minkovitz 2006). Thus, increasing adolescents' mental health literacy may reduce stigma regarding mental health problems and increase help-seeking for such problems. This is supported in a study that investigated whether mental health literacy among adolescents was improved by participating in a universal programme (Skre et al. 2013). Findings from this study showed a decline in prejudice beliefs among adolescents participating in a 3-day universal school intervention (Skre et al. 2013). However, interventions aiming to increase mental health literacy among school-aged adolescents should address prejudice regarding mental health issues prior to the intervention, as well as considering the students' maturity and age when developing such programmes (Skre et al. 2013; Penn et al. 2012), and, positive attitudes towards mental health among teens increase with both accurate knowledge regarding mental health and satisfactory personal experience (Chandra and Minkovitz 2007). Furthermore, studies have indicated that stigma rarely is associated with the labelling of mental disorders by using psychiatric or lay mental health terms and hence a distinction between labelling the person and labelling the problem should be made (Wright, Jorm, and Mackinnon 2011). Also, family conversations, particularly with parents, can have a positive influence on adolescents' perspectives on mental health (Chandra and Minkovitz 2007).

The adolescents in the current study primarily wanted school-based programmes with the possibility of both group-based interventions and individual conversations. Some of the adolescents suggested including information regarding mental health problems in the curriculum. The need to include stigma related to mental health problems in the school curricula has been suggested elsewhere (Chandra and Minkovitz 2007). The reason the adolescents in this study gave for preferring a school-based intervention was primarily to avoid stigmatising behaviour from peers. It seems that the adolescents believe that a mandatory universal programme may reduce both self-stigma and public stigma. If mandatory and carried out in one class at a time, it may seem as if the adolescents find programmes less stigmatising because all are recipients of the programme. In other words, if the adolescent experiences mental health problems s/he prefers to receive some help through a programme carried out in class in preference to seek help individually and hence expose his/herself to his/her peers by contacting for instance a teacher, school nurse or the adolescent health centre and possibly experience stigma-related behaviour. Interventions that are universally administered in schools may increase implementation feasibility and the adolescents' acceptance of the intervention (Pinto-Foltz, Logsdon, and Myers 2011), and to be successful universal programmes must be implemented to an entire school (Weare and Nind 2011). Furthermore, for interventions conducted at school, it may be useful for someone other than the regular teacher to be responsible. Some of the adolescents in the current study were sceptical of discussing mental health problems with their teacher and preferred the school nurse, a psychologist or others with the proper educational background. Ambivalence towards the involvement of teachers has been shown elsewhere (Chandra and Minkovitz 2007). Intervention results are also better when researchers, rather than teachers, carry out school-based interventions (Wilson et al. 2011, 8). Hence, both training of personnel and the hiring of implementers are likely to have major practical and economic impacts on the schools. However, as one of the students said, 'It may be expensive, but it is actually something the school needs' (Jakob, 18 years). If using professional caregivers, one should also be aware of professional and institutional stigma. Such stigma includes communicating shame and/or low expectations to the adolescents and their families through the caregivers' stigmatising attitudes and practices (Heflinger and Hinshaw 2010). However, in the long term, school-based programmes may be exactly what both adolescents and society as a whole need as such interventions may reduce barriers to help-seeking (e.g. anticipated stigma), improve the availability of mental health services and keep adolescents' expenses regarding mental health services to a minimum. School-based programmes partly developed on the adolescents' terms as presented in the above may be health promoting for the target group. However, more research is needed to draw conclusions on perceived stigma as well as programme satisfaction

in universal programmes compared with targeted programmes (Rapee et al. 2006). Also, although mental health literacy may increase, stigma regarding mental health problems has been found to be constant, suggesting a disconnection between adolescents' thoughts (mental health literacy) and feelings (stigma) (Pinto-Foltz, Logsdon, and Myers 2011). If this is the case, it should be taken into consideration when developing interventions for adolescents.

Channels for informing the adolescents about mental health services include social media, particularly Facebook. Using such channels may aid in increasing both knowledge regarding and help-seeking for mental health problems. The emphasis on social media/Internet as a source for knowledge also raises the question of potential utilisation of web-based interventions. Either way, adolescents need guidance and help to increase their knowledge regarding mental health problems. Studies have shown that parents and family should be engaged to encourage help-seeking from in-person mental health services, and proper guidance in the online environment is required to ensure that the adolescents receive proper help (Rickwood, Mazzer, and Telford 2015). For school-aged young people, studies have shown that school staff has an influence regarding attitudes towards mental health problems (Rickwood, Mazzer, and Telford 2015) and one role of teachers may be to help guide adolescents in the online environment.

Limitations of the study

The small sample and the purposive self-selection sampling of this study could represent a selection bias as the adolescents who did not participate might have important information. There were only two boys in the sample, and none of the interviewed adolescents was currently utilising mental health services. The sample had limited cultural diversity, and the age range was limited. Hence, results may have been different with another sample. Additionally, generalisability is limited as the sample also is a non-clinical community sample. A randomised sample of non-clinical older adolescents with more cultural diversity and age range could provide different results. Another question is whether the open-ended questions were broad enough and did not lead the adolescents into answering. Furthermore, the study only focused on intentional utilisation of services and not actual help-seeking. Perhaps, it would have been informative to differentiate between the two. Finally, the generalisability of the study is reduced because the use of mental health services and the availability of such services differ between countries. Thus, future research should take these limitations into consideration.

Conclusion

In this study, a community sample of Norwegian adolescents' knowledge of and wishes regarding mental health services was investigated as well as stigma-related barriers for help-seeking regarding such problems. One advantage of exploring this subject in a community sample is the knowledge that few adolescents receive appropriate help, and knowing more about what may hinder adolescents to address and seek help for such problems may aid health professionals in the 'what', 'how' and 'where' of mental health services for this target group. Hence, it is important to ask the adolescents themselves what services they wish would be available to them if necessary. This is important in relation to the fact that stigma-related barriers may be a critical intervention point (Chandra and Minkovitz 2007). The findings of this study suggest that adolescents experience anticipated stigma, personal stigma and perceived stigma and fear that help-seeking for mental health problems may lead to social distance. The school was viewed as a good place for informing about and carrying out interventions aiming to increase adolescents' coping. As the adolescents described mandatory programmes as less threatening when it comes to expected peers' prejudice a school-based programme may reduce anticipated stigma related to mental health problems. One method of increasing the adolescents' mental health literacy would be through universal programmes. However, more research is needed and both qualitative and quantitative data are

important contributions in this area (Clement et al. 2015; Heflinger and Hinshaw 2010). Findings also suggest that social media play a crucial part in terms of reaching adolescents with information on mental health services. This is important information for those wanting to reach adolescents with such information, such as mental health centres, recreation centres, and other non-school settings. Finally, findings from this study may contribute in developing effective mental health promotion campaigns in order to enhance the information that is provided to adolescents, and may be used to improve communication between health professionals, adolescents and families.

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